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ABSTRACT

This practicum focused on preventing referral to special education by meeting the needs of kindergarten and first grade children identified with behavioral or academic problems in the mainstream classroom. The practicum emphasized: (1) early identification of potentially dysfunctional children; (2) development of individual education plans addressing affective and cognitive domains; (3) intensive teacher inservice; (4) redesigned classrooms and curriculum; and (5) parent involvement. A strategic planning team was formed including six kindergarten and first grade teachers, the school psychologist, the school social worker, an exceptional education teacher, the curriculum resource teacher, and the counselor. Training was provided to all 30 teachers beginning during the semester's preplanning period and continuing on a monthly basis throughout the semester. Topics addressed in the workshops included: controlling dysfunctional behavior, compensating for developmental lags, utilizing the newly created identification instrument, reviewing referral procedures, and designing strategies that work for an individual teacher. Evaluation indicated that teachers became familiar with new strategies and substantially increased use of these strategies following training. However, referral for special education evaluation increased slightly over the previous year. Appendices include a Student Behavior Inventory with Related Teaching Strategies, an inservice pre/post test, a preferred strategies inventory, and a classroom observation instrument. (Contains 47 references.) (DB)

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ED 368 121

Developing a Comprehensive Model for the Inclusion and Support of the Academically Delayed and Behaviorally Disordered Elementary School Child in the Mainstream Classroom

by

Joyce A. Swanson

Cluster 47

A Practicum II Report Presented to the
Ed.D Program in Child and Youth Studies
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

NOVA UNIVERSITY

1994

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PRACTICUM APPROVAL SHEET

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This practicum report was submitted by Joyce A. Swanson under the direction of the adviser listed below. It was submitted to the Ed.D. Program in Child and Youth Studies and approved in partial fulfillment of the requirements for the degree of Doctor of Education at Nova University.

Approved:

2-3-94

Date of Final Approval of Report

Mary Staggs

Dr. Mary Staggs, Ed.D., Advisor

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Creativity is like a fragile flower. Given the proper sunlight, soil, and humidity it will bloom, filling the night air with a heady fragrance that revisits one's memory in those too infrequent quiet moments. This creative effort could never have happened without the dynamic leadership of Dr. Delores Inniss. She was not only willing to try something new but remained supportive throughout the struggle, frustration, and disappointment that met our efforts.

I wish to share my enormous respect for the faculty of Hungerford Elementary. This is especially true of Jackie Swinderman and Chartine Griffin who said those three magical words, "I'll do it." Without Connie Turner's support, knowledge, and belief in the program, we might have failed.

Finally, to my two practicum advisors, Dr. Mary Staggs and Dr. Barry Birnbaum, who both demanded the highest level of professionalism in the design and writing of my practicum reports, I owe a debt of gratitude that cannot be expressed. I found a part of myself I never knew existed. Thank you.

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ABSTRACT

Developing a Comprehensive Model for the Inclusion and Support of the Academically Delayed and Behaviorally Disordered Elementary School Child in the Mainstream Classroom. Swanson, Joyce A., 1993: Practicum Report, Nova University, Ed.D. Program in Child and Youth Studies. At Risk Persons/Behavior Problems/Learning Problems/Child Behavior/Family Violence/Child Abuse/Change Strategies/Teacher Responsibilities.

This practicum was designed to address the dramatic increase in the number of students in a low socio-economic, urban, elementary school demonstrating behaviors such as poor impulse control, inability to predict consequences, non-compliance, learning disabilities, and problems with self regulation, peer interaction, communication, judgement, and decision making. It was the goal of this practicum to meet the behavioral and academic needs of identified children in the mainstream classroom rather than referring them for exceptional education services.

The plan selected for implementation incorporated early identification of potentially dysfunctional children, development of individual education plans addressing affective and cognitive domains, intensive teacher in-service, redesigned classrooms and curriculum, and inclusion of parents in an actively supportive role.

Analysis of data indicted strong teacher support for strategic planning in addressing individual school problems. Following intensive in-service, teachers reported an increase in available strategies designed to meet the academic and behavioral needs of the dysfunctional children in their classrooms. Increased competence in classroom management techniques resulted in more appropriate referrals for exceptional education. Efforts to increase parent participation were largely unsuccessful.

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CHAPTER I

INTRODUCTION

Description of the Community

The community served by the writer's elementary school has many unique features. Incorporated as the first Black town in the United States over 100 years ago, the community continues strong ties to its original roots. Many of the current residents are direct descendants of the original founders. Extensive kinship among the students is common, with related families often sharing the same, tiny houses.

Despite the presence of many relatives within a small geographic area, the children attending the writer's school seem to have few stable family influences. Families served by the school are both extended and multigenerational. It is common to find related children with different parents being raised by a single female head of household. Some of these mothers work several low-paying jobs to make ends meet. Many are on welfare. Half of the population changes addresses frequently while the other half own homes that have been in the family for years.

One thing that most families in this community share in common is poverty. Ninety-one percent of the students attending the writer's elementary school are on free or reduced lunch. Some are poorly clothed. Health care is

sporadic or non-existent. Many fathers are absent or in jail. Violence in the home and in the community is a common occurrence, witnessed first hand by the children. Drug addiction, neglect, lack of parental supervision, and child and spousal abuse present real threats to the children growing up in this community.

Writer's Work Setting and Role

The writer's school serves 386 students in grades pre-kindergarten to fifth. While several different cultures are represented in the student body, the predominant culture is African-American. Dialect, music, and traditional stories are external expressions of the rich culture that has been handed down to the predominantly Black student body.

In addition to the traditional curriculum, the school offers a Minority Access Gifted Program, two varying exceptionalities resource rooms, and remediation in math and reading for economically disadvantages children scoring below national norms. Curriculum presented in learning centers focused around computers formed the basis of a very successful pilot program initiated last year.

As guidance counselor, the writer is responsible for crisis intervention, individual and group counseling, classroom instruction, consultation with parents, teachers, administration, and community members, and coordination of exceptional education referrals and staffing functions.

CHAPTER II

STUDY OF THE PROBLEM

Problem Description

While the community served by the writer's school may be unique, the problems faced within the school are not. In the past two years there has been a dramatic increase in the number of children in the primary grades being referred for placement in exceptional education programs because of severely dysfunctional school behaviors.

The behaviors causing concern included distractibility, poor impulse control, irritability, inability to predict consequences, non-compliance, learning disabilities, and problems with self regulation, peer interaction, communication, judgement, and decision making.

Older children receiving referral for evaluation for exceptional education programs displayed behavioral patterns containing three or four of the symptomatic behaviors including problems with peer interactions, learning disabilities, and non-compliance. The children referred from the primary grades presented constellations that contain most, if not all, of these dysfunctional behaviors.

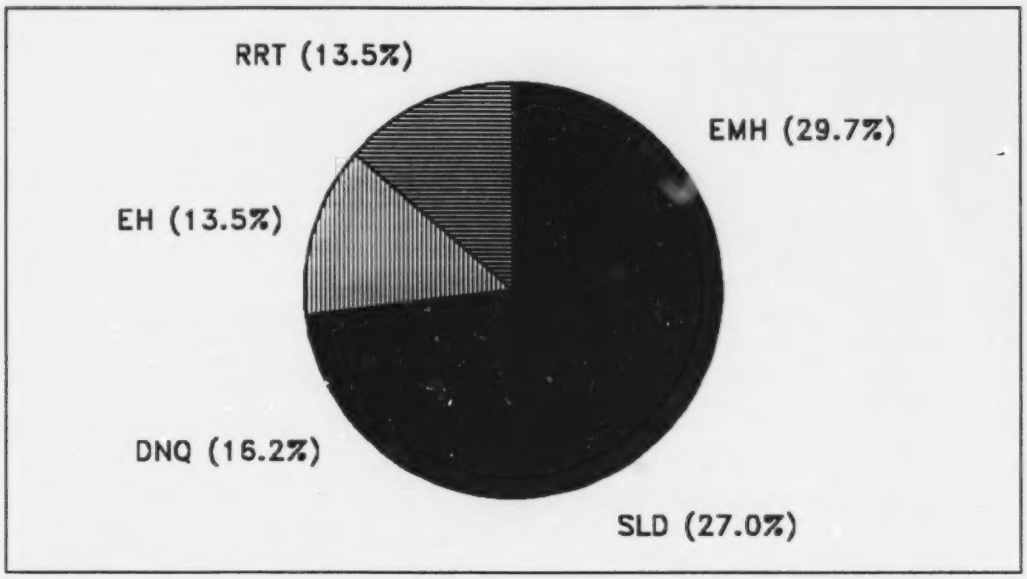
Severity was also different with the younger children displaying extreme aggression and greater volatility. The younger children, many as early as pre-kindergarten, were

coming to school completely out-of-control. They threw objects in the room, kicked, hit, screamed, jumped from table to table, and became physically assaultive toward adults trying to restrain them. A teacher faced with one such child in the room would have a severe management problem. Unfortunately, at least one classroom out of six had three children exhibiting these extreme behaviors. Management became impossible because these "contagious" behaviors acted like a virus on marginally controlled children setting a pattern for the rest of their school experience.

Problem Documentation

Referrals for exceptional education services, other than speech and language, have gone from eleven for the entire '91-'92 school year to 35 in '92-'93, 17 of which were made in the first semester (see Figure 1). Last year two students were placed in the emotionally handicapped program. During the first semester of '92-'93 five were referred or placed, three of whom were kindergarten students. All of the children referred for the emotionally handicapped program displayed highly impulsive behaviors dangerous to themselves or others, episodes of violence such as throwing chairs, hitting others with objects like staplers, running from adults, refusal to follow directions, and wildly changing mood swings.

Figure 1
Psychological Services for '92–'93



Legend:

EMH ... Educable Mentally Handicapped
SLD ... Specific Learning Disabilities
EH ... Emotionally Handicapped
DNQ ... Did Not Qualify
RRT ... Re-evaluation Review Team

Referrals for various learning disabilities also increased. During an informal survey of the three first grades, one teacher referred 9 of 20 students; one listed 5 of 20 as having problems, while a third teacher identified 5 of 19 as possibly needing referral at a later date. Kindergarten teachers estimate 4 of a total of 53 students may be learning disabled. However, kindergarten teachers are reluctant to refer children for testing because developmental rates fluctuate so dramatically at this age.

The same survey of kindergarten and first grade teachers indicated that classes seemed to be more difficult to manage. The number of behavior problems increased last year. The behaviors being observed were more severe and required more forceful intervention to maintain safety and control. In addition, more children seemed to require individual attention in order to master material being presented.

Teachers working in the primary grades requested the formation of a strategic planning team to address their concerns regarding the increase in "hard to manage" children currently effecting the daily operation of their classrooms. Current strategies did not seem to successfully meet the educational and emotional needs of each of the students. Time spent in "managing" behavior was taking away time from instruction, hurting those who were prepared to learn.

Others who needed academic and behavioral interventions were not able to function in the "typical" classroom milieu designed to meet the academic and social needs of the "average" child.

Observations during counseling supported teacher perception that children were experiencing learning and behavioral problems in the classroom resulting in lower self-esteem and feelings of failure. While many of the children referred for counseling wanted to be at school, they did not feel comfortable in the classroom. Many experienced poor peer relationships. Some reported not knowing how to control their personal environment. Others were unfocused in class, felt overwhelmed by the difficulty in assignments, and resorted to inappropriate social behavior to retrieve feelings of self-worth.

Counseling sessions with both parents and students indicated that the behavior existed at home as well as at school. Parents expressed feelings of frustration about their failure to help their children manage negative behaviors. Some parents began to actively seek professional input and referral from the school as measured by the increase from three parent-requested Educational Planning Team conferences in '91-'92 to 12 parent-initiated conferences in the first five months of the '92-'93 school year.

Causative Analysis

Behavioral dysfunction and learning disabilities might be caused by any one of a variety of genetic, prenatal or post-natal environmental factors. Prenatal exposure to toxic substances such as "crack," a solid or "rock" form of cocaine, alcohol, lead, some prescription drugs, and certain disease producing organisms can influence fetal development. Inadequate maternal health care as a result of poverty, lack of adequate insurance, unwanted pregnancies, and dysfunctional family systems could result in low birth weight and prematurity, significantly impacting infant development.

Environmental factors play an extremely important role in the post-natal development of the child. Dysfunctional families, often the result of societal influences such as poverty, drug addiction, and family violence, experience great difficulties providing the structure and security necessary for strong emotional development. The drug-addicted parent may be unable to foster bonding with the infant. Family violence becomes the model for the child who is learning social behavior. Abuse and neglect can have a direct impact on the child's physical and emotional development.

The occurrence of multiple caregivers is common in dysfunctional families. Grandparents, close relatives, older siblings, and day care are often used to replace the

"absent" mother who is unable to fulfill her role because of addiction, irresponsibility, or age. Infant development requires consistent caregiving in order to promote bonding, trust, security, needs fulfillment, and moral development. The unbonded child can develop into a severely troubled adult.

Single parent family configurations face several challenges. Single parents are disproportionately poor, young, and without resources to cope adequately with the demands of an infant. It is often difficult, if not impossible, for one parent, especially a working parent, to provide the adequate structure, nurture, and stimulation necessary for strong emotional growth.

While most of these influences cut across socio-economic and racial lines, they appear to be most closely related to those who live in poverty. Because most of the children attending the writer's school come from poor families, the probability of poverty's impact on development must be considered.

Relationship of the Problem to the Literature

There is an abundance of literature addressing the severely dysfunctional behavior of many children entering the primary grades. While intrauterine exposure to "crack" has received much of the researchers' attention, other factors can be as devastating to the developing child

(Bartel & Thurman, 1992; Durfee & Tilton-Durfee, 1990; Fejes-Mendoza, 1991; Howze & Howze, 1989; Linehan, 1992).

Until recently, researchers reported that prenatal exposure to drugs, especially "crack," was a major contributor to the behavior and learning problems being experienced by primary aged children. Estimates indicate that 375,000, or 11 percent of newborns, are exposed prenatally to illegal drugs (Gittler & McPherson, 1990; Howze & Howze, 1989).

Within the last six years, "crack" cocaine has become the popular drug of choice because it is both relatively cheap and easily accessible. As a result, approximately 1.6 million women of child-bearing age are regular users of "crack" (Howze & Howze, 1989). It is estimated that exposure to "crack" impacts between 50,000 and 100,000 births. Many infants born to addicted mothers are underweight and premature (Bartel & Thurman, 1992).

The amount of damage sustained by the developing fetus depends on the timing, amounts ingested, and duration of exposure, as well as the lack of prenatal care and general maternal nutrition (Lockwood, 1990; Stevens & Price, 1992). Infant distress due to exposure to "crack" is initially symptomatic of drug withdrawal (Rickarby, 1984). Exposed infants are often jittery, restless, and irritable. They experience disrupted eating and sleep patterns and an inability to signal accurately their biological and emotional needs (Bartel & Thurman, 1992).

While the actual neurological damage to the infant by exposure may decrease over time, behavioral patterns established in early infancy can interrupt the entire "bonding" process (Bartel & Thurman, 1992; Bauer, 1991; Bauer, Buschbarger, Ellis, & Whelley, 1990; Streissguth, Sampson, & Barr, 1989).

Bonding refers to the successful attachment of the infant to the primary caregiver. By three to eight months, the child begins to develop appropriate social interactions with the caregiver. If the caregiver changes frequently or is separated from the infant due to hospitalization, death, physical inability to care for the infant, or continued addiction, bonding can be destroyed (Bartel & Thurman, 1992; Bauer, 1991; Bauer, et.al., 1990; Rickarby, 1984).

Trust that is necessary for a secure bond is built upon consistent, immediate, and appropriate responses to the infant's signals (Bartel & Thurman, 1992; Howze & Howze, 1989). Often the addicted parent is unwilling or incapable of providing even minimal interaction with an infant. Many are single parents, financially dependent, socially isolated, naive about child development, and victims of physical and sexual abuse as children (Griffith, 1992; Howard, Beckwith, Rodning, & Kropenske, 1991; Vincent, Poulsen, Cole, Woodruff, & Griffith, 1991). When maternal impairment happens in a matriarchal system such as that associated with Black families, children wind up being reared by older grandmothers often responsible for the care

and nurturing of several preschool children (Select Committee on Narcotics Abuse and Control, 1991).

Bonding problems do not end with infancy. Children with attachment problems have trouble in social interactions with their peers (Bauer, et.al., 1990). Negative behaviors exhibited by the older, marginally bonded child include superficial, shallow relationships, anger, aggressiveness, lack of self-worth, poor peer relationships, anxiety, depression, and incompetence in controlling one's environment (Howes, 1989; Rickarby, 1984).

Symptoms of prenatal drug exposure are very similar to those caused by membership in a violent or severely dysfunctional family, exposure to lead, being attention deficit disordered, homeless, or unwanted (Barkley, DuPaul, & McMurray, 1990; Bartel & Thurman, 1992; Bauer, 1991; Burgess & Streissguth, 1992; Durbin, 1993; Griesbach & Polloway, 1990; Linehan, 1992; Needleman, 1992). Table 1 compares the symptoms held in common which include irritability, poor impulse control, lack of goal-directed behavior, inability to anticipate consequences, frustration, distractibility, expressive language difficulties, and insecure attachment to the primary caregiver, poor social judgment, depression, and learning and developmental delays.

Dysfunctional school-based behaviors can be divided into five major areas: difficulties with judgment and decision making, issues of non-compliance, problems with

TABLE 1

Comparison of School-Based Behavioral Manifestations Associated with Six Major Prenatal and Environmental Factors.

SYMPTOMS	C-x	A-x	L-x	ADD	FV	N-B
Poor Social Judgement	X	X		X	X	X
Poor Impulse Control	X	X		X		X
Unable to Anticipate Consequences	X	X		X	X	
Aggression/Anger/Antisocial Behavior			X	X	X	X
Poor Peer Relations	X	X		X	X	X
Insecure Attachments	X	X			X	X
Difficulty Controlling One's Own Environment	X		X	X	X	X
Irritability/Distractibility	X		X	X		X
Lack of Goal Directed Behavior	X			X		
Frustration	X	X		X		X
Anxiety		X		X		X
Depression		X				X
Learning/Developmental Delays		X	X	X		
Language Development Delay/Poor Communication Skills	X	X	X		X	

LEGEND:
C-x Prenatal Crack cocaine exposure
A-x Prenatal Exposure to Alcohol
L-x Environmental Exposure to Lead
ADD Attention Deficit Disorder
FV Children Impacted by Family Violence
N-B Children Experiencing Failure to Bond

(Information compiled from related Literature.)

self-regulation, language and communication gaps, and difficulties with social relationships.

Judgment and decision-making difficulties often stem from the child's inability to establish an internal "locus of control" (Stevens & Price, 1992). Children living with family violence or severe family dysfunction are especially prone to establishment of an external locus of control since they are virtually powerless to control their immediate environment (Breiner, 1987; Otto & Brown, 1985; Rancer & Niemasz, 1988; Straus & Kantor, 1988; Swanson, 1992, 1993). As a result, they are unable to define boundaries and control their behavior in response to those boundaries. In addition, these children seem unable to differentiate feelings from actions, responding to every "feeling" impulsively without regard to consequences (Craig, 1992; Swanson, 1993).

Non-compliance includes such behaviors as aggressiveness, loss of self-control, and an inability to respond appropriately to adults in the child's immediate environment (Stevens & Price, 1992). Risk factors for non-compliance include low socio-economic status, chaotic family environment, lack of structure, inappropriate stimulation, and maternal hostility (Erickson, et.al., 1982). Compliance is based on the affection and trust that grows out of successful bonding.

Self-regulation includes the ability to absorb and

integrate change while exhibiting appropriate needs-fulfilling behavior (Bauer, et.al., 1990; Stevens & Price, 1992). Difficulties with self-regulation frequently result from prenatal exposure to drugs. However, children raised in sterile environments often associated with poverty, homelessness, and severely dysfunctional families are also unable to handle the stimulation associated with school (Gregorchik, 1992).

Language and communication delays, the fourth area of school dysfunction, are often associated with exposure to lead, violence, and prenatal exposure to drugs and alcohol (Craig, 1992; Stevens & Price, 1992). Language is important because it permits the child to respond to and react appropriately in his environment. Delays in receptive language tend to isolate the child (Stevens & Price, 1992). Communication, as it is used by dysfunctional children, tends to be gesture oriented and used to define relationships, especially dominance, rather than communicate meaning (Craig, 1992).

Difficulties with social relationships which include impulsivity, poor communications, and an inability to predict consequences can result from both pre and post-delivery influences. Dysfunctional and violent families teach children how to behave through modeling. Children learn social interactions in "chunks" through observation as well as through participation (Bandura, 1977, 1979). Those children raised in violence prone families often do not have

models from which to acquire the skills necessary to initiate positive social interactions (Craig, 1992; Swanson, 1993). Abused and poorly bonded children have additional difficulties with trust issues, validation of feelings, and interpreting the actions of others according to Stevens and Price (1992).

CHAPTER III

ANTICIPATE OUTCOMES AND EVALUATION INSTRUMENTS

Goals and Expectations

There has been a dramatic increase in the number of children in the primary grades of the writer's school being referred for placement in exceptional education programs because of severely dysfunctional behavior, poor academic performance, or both.

The overall goal of this practicum was to create a classroom environment designed to meet the individual developmental needs of each child within the mainstream classroom setting.

Expected Outcomes

The following outcomes were projected in order to create a classroom environment that will meet the special academic and behavioral needs of children who are experiencing significant adjustment problems without removing that student from the mainstream classroom.

1. Teachers will demonstrate appropriate strategies to handle children with developmental delays and moderately dysfunctional behavioral problems in their mainstream classrooms.

2. Referrals for exceptional education programs other than speech and language will remain constant or decrease from the '92-'93 level of 17 referrals in the first semester.

3. Parent participation in their children's educational experience will increase.

Measurement of Outcomes

The first outcome, teacher demonstration of appropriate strategies to handle developmentally delayed or behaviorally dysfunctional children in their mainstream classrooms, was measured in two ways.

Measurement of an increase in teacher familiarity with available strategies and interventions for managing the behavior of volatile children and meeting special academic needs of those who are developmentally delayed was based on scores obtained from a writer designed pre/post test.

It was also important to determine whether there was actual teacher implementation of strategies for behavioral management and academic compensation. In order to measure teacher implementation of selected strategies, a self-report inventory was administered. Comparisons between frequency of use of available strategies at the beginning and the end of the eight week period were generated.

The writer's second outcome was to hold referrals for exceptional education services steady or effect a decrease by serving each child's needs fully within the mainstream

classroom. Therefore, actual referrals for the first semester of '92-'93 were compared to the referrals for the first semester of '93-'94.

The third outcome, an increase in parent participation, was measured in two ways. Parent attendance at educational planning team meetings was recorded and charted. Parent attendance at parent/teacher conferences was also recorded and charted for trends.

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluation of Possible Solutions

There has been a dramatic increase in the number of children in the primary grades of the writer's school being referred for placement in exceptional education programs because of severely dysfunctional classroom behavior, poor academic performance, or both. Current literature suggests a number of approaches for working with behaviorally and educationally at-risk students. Five potential solutions to the problem have been reviewed.

Early intervention strategies and family systems approach are both models for delivering comprehensive social services to the child and his family. Both models are based on the philosophy that the child is solely responsible for his dysfunction. However, he is not powerful enough to effect a dramatic change in his environment. Therefore, either the primary caregiver or the entire family group needs to be incorporated in any treatment plan if there are to be significant changes in the child's behavior.

Early intervention efforts aimed at the pre-school child often start during pregnancy in the form of maternal health care, nutrition, or drug treatment. Family systems can begin at any point during the family's life experience.

Family systems counseling also includes all members of the family unit, striving for competence and emotional health in all members of the family (Horowitz, 1990; Vincent, et.al., 1991; Wright, 1981). Early intervention can target the entire family but often serves only the child and the primary caregiver (Committee on the Judiciary, 1992; Gittler & McPherson, 1990; Griffin, 1992; Minisman-Chin, Snyder-Spatarella, & Tansey, 1991).

Both approaches are designed to be long-term, multidisciplinary, and broad-based, offering a multiplicity of services. Early intervention tends to be preventative while family systems is curative. Services offered early to child and parents can help prevent developmental delays by offering increased stimulation, appropriate child-rearing information, and timely medical intervention, when appropriate. Through a strong parent-professional tie, the parent is also helped to grow in confidence when interacting with the child thus strengthening the bonding process begun in infancy (Minisman-Chin, et.al., 1991).

Early intervention strategies are currently being offered at the writer's school through a federally funded program called First Start. Parents with their young children attend weekly sessions where parenting skills are modeled while the children enjoy supervised play time. Home visits are conducted on a regular basis. While extremely valuable, this model does not offer support to the student already attending school.

Comprehensive family-oriented services have a place in any approach developed for use with school aged children. While it is not feasible at this time to deliver a whole array of social services, some component parts can be "borrowed" from the overall concept. Certainly parents, if not entire family groups, should be included in the planning for and encouragement of the school-aged child. Parenting classes, regular counseling, and family social services support delivered by the school social worker should help to relieve some of the negative parental pressure exerted upon the child. Parents would then be better able to model appropriate behaviors once they learn how to use them to solve their own problems. With a more positive outlook, newly acquired parenting skills, and an increased energy level from resolving many depressing concerns, the parents should be better able to encourage, support, and enrich the child.

Children prenatally exposed to drugs or alcohol have difficulty with impulse control, anticipation of consequences, and poor social judgment (Folz, 1990). They need structure and logical consequences. Behavior modification strategies offer parents and teachers techniques for dealing appropriately with negative behaviors both at home and in school. They can be used to create a structured environment based on a system of appropriate, understandable rules and natural consequences (Barth, 1991;

Burgess & Streissguth, 1992; Cole, Jones, & Sadofsky, 1990; Durbin, 1993; D'Entremont, 1990; Folz, 1990).

Once established and clearly understood, the rules and consequences are reinforced consistently and predictably. Since consistency and predictability are two conditions not commonly found in highly dysfunctional households, children need time to adjust. Behavior modification continues until negative behaviors are extinguished and an array of positive behaviors are substituted.

Teachers can also become proactive in assisting students to make the transition to the school environment. For example, instruction in cognitive strategies has been utilized to increase the at-risk student's ability to manage his/her own behavior (Griffith, 1992; Swanson, 1993). Many children come to school unprepared to handle the structure of the classroom and the complexity of the development skills necessary to achieve academically. They have had little intellectual stimulation in the home, marginal or negative role modeling of social skills, and a lack of experience in deferred gratification. Low self-esteem, high levels of frustration, and an enormous gap between teacher expectations and the reality of survival prepare children entering school for failure. Social skills training increases the number of "tools" available to the child to control his behavior and achieve gratification rather than frustration and defeat.

Providing children with tools to manage their behavior is one-half of the equation. Teachers also have a number of strategies available to manipulate the classroom environment and curriculum to meet the educational and behavioral needs of the highly dysfunctional child (Bauer, et.al., 1991; Harpring, 1992; Prenatally Exposed to Drugs (PED) Program, 1989). Techniques such as controlling the amount and presentation of visual and auditory stimulation can prevent a child from becoming overly excited and losing control. Planned, orderly transitions, clear expectations, and a consistent, predictable classroom environment with the same teacher for several years can introduce stability and foster self-control. Learning centers stocked with hands-on manipulatives permit the hyperactive child to change focus frequently without being disruptive (Bauer, 1991; Lumsden, 1990).

The Los Angeles' Program for Children Prenatally Exposed to Drugs (1989) has incorporated elements from each of the above. Using an interdisciplinary team, prenatally drug exposed children ages 3-6 are assessed for related medical problems, learning style, developmental levels, behavioral characteristics, and social skills competency. Curriculum is developed for each individual child incorporating motor/neurological development, affective/behavioral development, social/attachment development, problem-solving, language, and play. Parental-professional teamwork is considered crucial to the overall

success of the program. Teacher training, development of appropriate curriculum to meet the special needs of these at-risk children, and generation of data have evolved as important elements of the overall program.

Placement in exceptional education programs to help the child compensate for emotional handicaps, developmental shortfalls in intellect, or physiologically based processing problems is the last option in addressing the needs of the dysfunctional child in the school setting. Philosophically, placement in exceptional education indicates a failure to meet the special needs presented by that child in the mainstream classroom setting. Inclusion of all children in the regular classrooms is becoming a legal as well as a moral issue to be addressed by educators in the field.

Description of Selected Solution

The initial plan selected for implementation early in the first semester of the '93-'94 school year incorporated the broad guidelines of the plan developed by the Los Angeles' Program for Children Prenatally Exposed to Drugs. As with the PED program, early identification and referral, inclusion of parents in an actively supportive role, development of individual education plans addressing affective and cognitive domains, redesigned classrooms and curriculum, and an interdisciplinary network of

professionals offering a variety of support services was included. Redesigned classrooms had to be eliminated from the implementation stage of the plan due to a cut in teacher allotment with a resulting increase in class size.

Report of Action Taken

Since teachers had signaled the need for finding some reasonable way to mange the influx of dysfunctional children, implementation began with the formation of a strategic planning team. The team included six kindergarten and first grade teachers, the school psychologist, school social worker, an exceptional education teacher, the curriculum resource teacher, and the counselor.

The strategic plan developed from the series of six meetings held late in the '92-'93 school year incorporated early identification and referral, inclusion of parents in an actively supportive role, redesigned classrooms and curriculum, extensive in-service training for teachers, and an interdisciplinary network of professionals offering a variety of support services.

The original plan called for early identification in the form of screening administered to all kindergarden and first grade students. Those students evidencing significant developmental gaps were to be referred to a support teacher who would enhance the curriculum to meet the needs of each child. The child was to be served in a small class setting utilizing a center approach to learning. After instruction,

the child was to return to his/her mainstream classroom for socialization activities.

Before implementation could begin, budget cuts resulted in the loss of the teaching position assigned to the supportive classroom environment. As a result, redesigned classrooms had to be eliminated. However, screening continued as scheduled. The teachers utilized the information based on screening results to design individual plans for developmentally delayed students which they attempted to implement within their individual classrooms with resources on hand. Administration supported continued efforts to meet individual demands through allotment of additional time and alleviation of extra duties. Support continued until the administrator was reassigned.

Several unexpected additions to the overall plan grew out of that strategic planning process. The "teaming" process necessary to the formulation of a working blueprint for implementation became the cornerstone providing the resiliency to manage the changes which impacted the implementation of the plan at every level. Personnel changes, cuts in budget, loss of the teacher position assigned to the special classroom setting, increased class sizes, and, finally, the loss of the administrator who had invested leadership and support in this innovative project all provided opportunity for failure. Instead of giving up,

these empowered, thoroughly invested group members managed change through constructive problem-solving.

The second major contribution was the development of a teacher-friendly screening device that permitted teachers to identify dysfunctional student behavior on a checklist (see Appendix A). Once behaviors were identified, a cluster descriptor was assigned. Matching strategies for intervention were paired with descriptors. Teachers were instructed in the use of this instrument and given an opportunity to practice manipulation of the materials during an in-service workshop.

Training for all teachers was considered to be crucial to the overall strategy. Current educational trends recognize mainstreaming and inclusion as desirable goals for all children regardless of handicap. As a result, many children who would have been served in exceptional education classrooms are now spending more time in regular classes. All teachers need to be aware of strategies that permit each child to experience some level of academic success while responsibly managing his own behavior. Therefore, it was decided that participation in training would be universal, actively encouraged, and on-going.

The purpose behind training was to increase teacher understanding of dynamics that cause observable behaviors as well as strategies and interventions to deal successfully with those behaviors. Teachers who continue at challenging schools are often intrinsically motivated to help. That

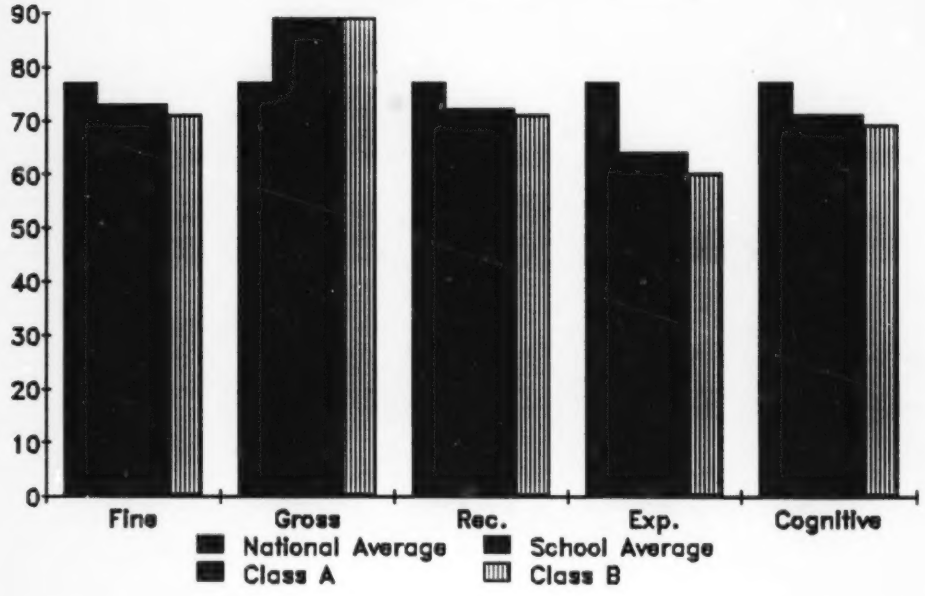
strength, coupled with relevant information, should increase sensitivity to the child's problems rather than anger and frustration. However, presentation of workable, concrete teaching strategies and behavioral interventions was crucial to give these highly motivated teachers tools that would prove successful thus insuring the continued use of that particular strategy.

Training began during preplanning and continued in one and a half hour sessions offered throughout the first semester. Topics included controlling dysfunctional behavior, compensating for developmental lags, utilizing the newly created identification instrument, reviewing referral procedures and documentation for exceptional education, and designing strategies that worked for each individual teacher. A writer designed pre/post test was administered to determine the amount of growth in teacher knowledge about strategies (see Appendix B). A teacher self-report determined the perceived increase in actual utilization of newly acquired strategies (see Appendix C). An objective instrument to measure teacher acquisition was designed but not utilized. The workshop generated between 10 and 24 hours toward re-certification depending upon the degree of additional independent study undertaken by each teacher. The emphasis of training was on causation, management techniques, and assessment.

The interdisciplinary team was responsible for conducting rough screenings to determine the intellectual, social, and academic "readiness" for school of each child enrolled in the first grade during the first semester of 1993-94. Results were obtained for each class as well as for the total first grade. The results comparing each first grade class, school totals, and national averages appear in Figure 2.

Figure 2

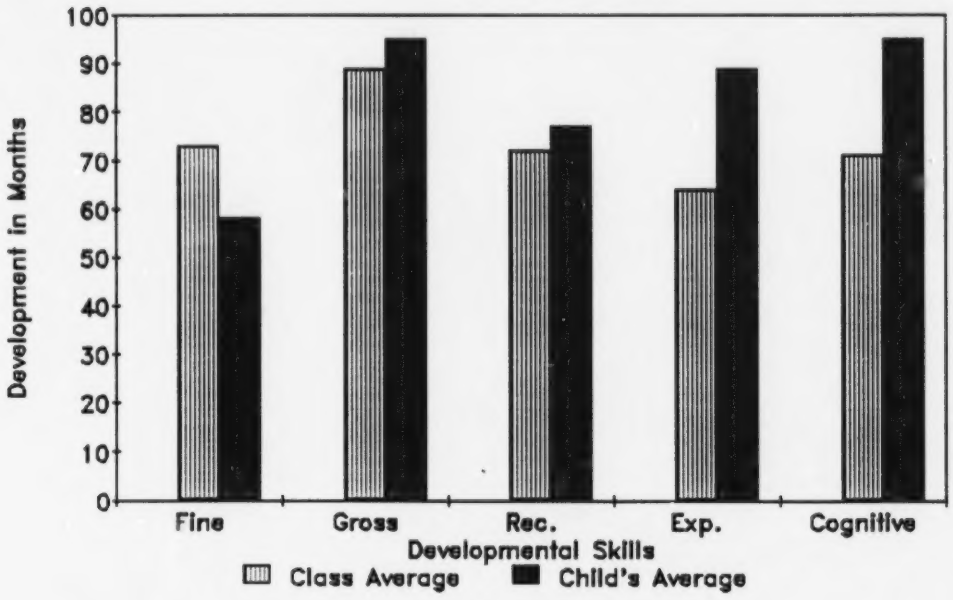
Class Comparison to National Average



Teacher observations, parent input, and screening results combined to create a picture of each child. Interdisciplinary team meetings were scheduled to develop recommendations for those children identified as needing additional academic and social development. Scores derived from the screening process were graphically represented for interpretation during parent/teacher meetings (see Figure 3).

Figure 3

Individual Development Chart



Active parent involvement in support of the student was addressed as the third side of the triangle. Parent/teacher meetings were scheduled on a regular basis to build good communication between school and home. Parents were included in the educational planning team meetings designed to develop individual education plans for each referred child. Family counseling was provided, as needed.

CHAPTER V

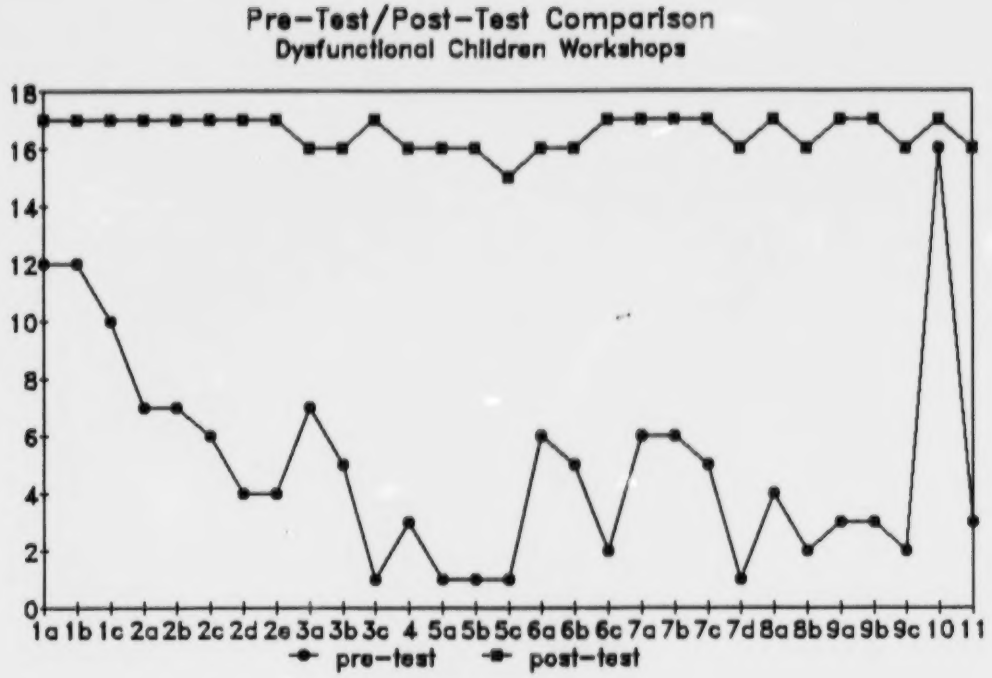
RESULTS, DISCUSSION, and RECOMMENDATIONS

Results

There has been a dramatic increase in the number of children in the primary grades of the writer's school being referred for placement in exceptional education programs because of severely dysfunctional classroom behavior, poor academic performance, or both.

The first objective was to increase teacher familiarity with appropriate behavioral and academic classroom management techniques. A series of workshops addressing causation, strategies, and referrals techniques were offered. Attendance was charted to measure teacher exposure to strategies for classroom management. Attendance at the monthly workshops ranged from 22 out of 30 to 29 out of 30 possible and included the entire faculty and staff.

Teacher familiarity with selected classroom strategies was measured by the pre/post test method required for documentation for in-service points. Seventeen of the original 19 respondents completed the post-test. Evidence of a dramatic increase in familiarity with offered material is demonstrated in Figure 4.



While dramatic, the results are not considered to be a true estimation of the amount of change in familiarity for two reasons. In order to obtain in-service credits for attendance at training sessions each participant must show a positive change in the amount of knowledge gained through exposure to the material. In order to assure the necessary growth, most teachers leave answers blank on the pretest instrument even when they are reasonably certain that they know the correct answer. That trend yields unrealistically low initial levels making final levels appear disproportionately greater than they really are. In addition, notes were permitted on the post-test allowing the teacher to look up answers, if needed. Therefore, the

dramatic increase in correct responses better measured the teachers' ability to identify appropriate classroom management strategies from a variety of resources. They also demonstrated the ability to find and utilize correct procedures in making referrals for exceptional education.

The fact that teachers at the writer's site have become more familiar with appropriate management strategies does not mean that they have incorporated those strategies on a regular basis in their classrooms. The second part of this objective was for teachers to successfully implement selected strategies to manage dysfunctional behavior in the mainstream classroom.

In order to measure changes in teacher utilization of new strategies, an objective observation instrument was designed to be used during each of three observations (see Appendix D). However, changes in personnel prevented utilization of this stronger, more objective measurement technique to determine teacher implementation of newly acquired strategies. Instead of the observation instrument, a self-report measure was developed to determine each teacher's perception of changes in her utilization of appropriate academic and behavioral management techniques in the classroom.

The self-report instrument was administered at the

beginning of the '93-'94 school year and again four months later. The perceived changes in use of strategies in the classroom are presented in Figure 5.

An analysis of individual teachers' responses indicated an increased use of positive strategies ranging from -5 to +14 over strategies listed as "used frequently" during the initial self-report administered before the beginning of the in-service workshops. In general, strategies "used occasionally" changed in direct proportion to the increase or decrease in reported frequent use of positive strategies.

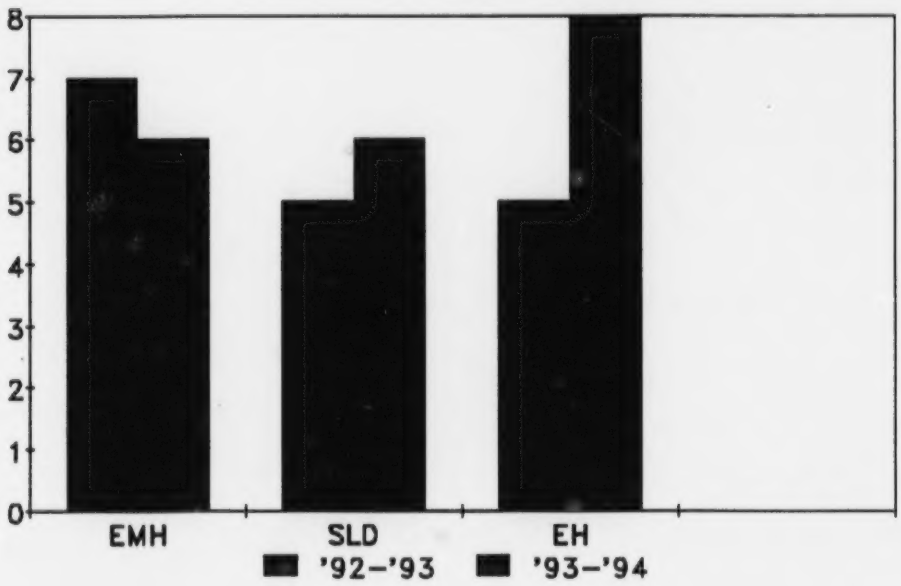
In a few instances, however, teachers reported not using certain strategies at all.

Without objective data, it can't be determined if teachers actually increased the frequency of use of positive strategies in dealing with children in their classrooms. However, the perception by the majority of teachers that they use positive strategies more often to motivate students may indicate an increased perception of competency in dealing with challenging children.

Successful teacher implementation of newly acquired strategies designed to maintain behaviorally and academically at-risk students in the mainstream classroom was expected to lead to a drop in exceptional education referrals. It was predicted that referrals for any program other than speech or language would remain constant or decrease from the '92-'93 level of 17 referrals in the first semester.

Referrals for exceptional education during the first semester of the '93-'94 school year took two forms. Classroom teachers initiated 24 referrals, four of which were for the gifted program (MAG/Gifted). The other referrals included six students for the educable mentally handicapped program (EMH), six students for specific learning disabilities (SLD), and eight students for the emotionally handicapped program (EH). This represented an increase of three students over the same time period the previous year. The results are included in Figure 6.

Figure 6
Teacher Initiated ESE Referrals

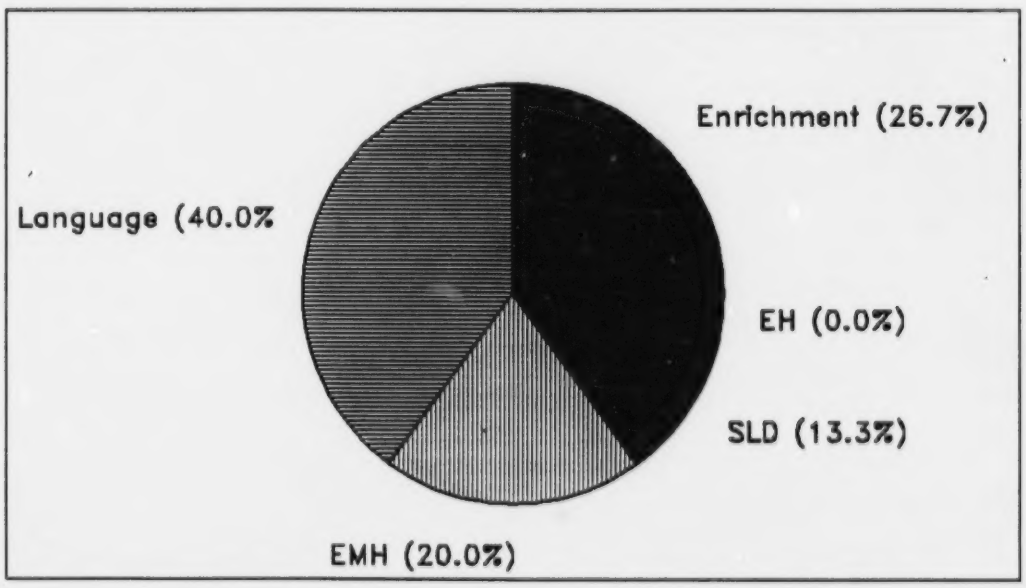


The second source of referral for the '93-'94 school year came from the early identification of children with special educational or behavioral needs. In an attempt to uncover potential problems early, all first graders were screened using the Battelle Developmental Inventory Screening Test (1984). Twenty children were identified as having subscore patterns suggesting the need for further evaluation. Of the twenty, six students achieved scores equivalent to those that might be found in students in the EMH range. The Slosson Intelligence Test - R (1991) was

administered to these students to verify initial findings.

Three students demonstrated patterns suggesting the possibility of specific learning disabilities. Eight students showed strength in all areas and were considered for the minority access to gifted services program. Thirteen first graders out of a total of 60 showed severe deficits in the language skills areas. These 13 students were in addition to the six whose scores placed them in the EMH range. Together the 19 students represent almost one-quarter of the first grade for whom the acquisition and utilization of language skills are a problem.

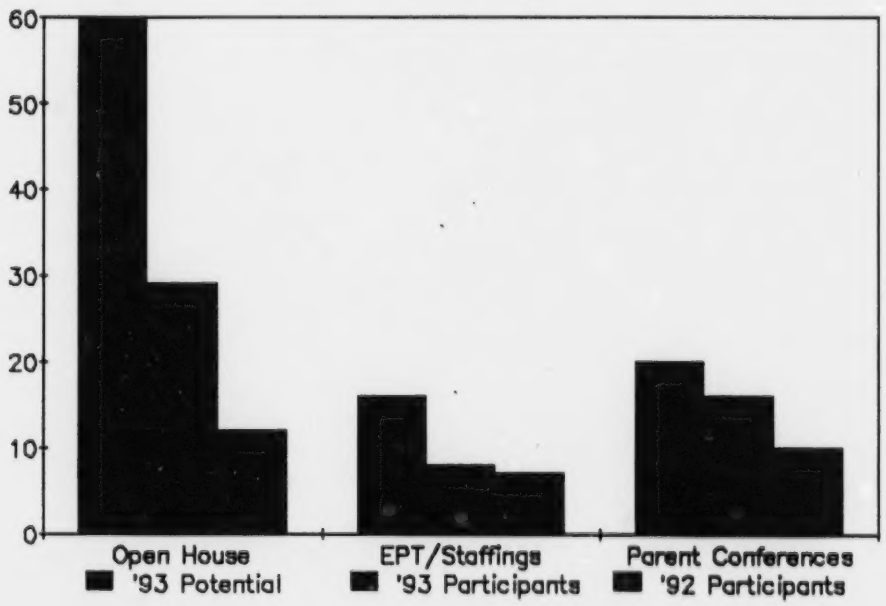
Figure 7
Screening Based Referrals



Once results were obtained, teachers were consulted to determine if classroom performance supported initial evaluation. In some cases it did not, suggesting further screening. Interestingly, in each instance when test results and teacher perceptions differed, teachers were supported by the use of a second screening instrument.

The final goal of this practicum was to increase parent participation. An effort was made to involve parents with the school in a positive, supportive manner. Individual invitations to open house were sent to each family. The two first grade teachers each invited one family per week to dine at a near-by fast food restaurant. As a result of these efforts, parent participation increased over previous years (see Figure 8).

Figure 8
Parent Participation



Discussion

This practicum addressed perceptions rather than facts. Specifically addressed were perceptions of increased dysfunctional pupil behaviors, perceptions of teacher inadequacy to deal with increasing classroom management demands, and perceptions of increased adequacy in incorporating new strategies for managing academically and behaviorally challenging students. Finally, perceptions about the "helpfulness" of the workshops were important to assimilation and generalization of the material offered by the facilitators. Significant behavioral changes rarely take place without the perception of relevance and ownership.

Validation of teacher concerns, inclusion of teachers in the planning and implementation phase, collaboration with teachers in the finalization of referrals lists, and the presentation of a variety of strategies perceived as helpful and relevant in increasing teacher strategy-based competency were the most lasting changes achieved during the practicum process.

Early identification of students' needs and appropriate strategies to help overcome areas of weakness before the student begins to experience frustration, loss of self-esteem, and hopelessness is important to each child's future participation in the educational process. However, of all the goals set out by this practicum, early identification and development of compensatory systems within the

mainstream classroom are the most vulnerable to personnel changes, budget cuts, and large classes.

Recommendations

As a result of the experiences gained during this practicum experience, five recommendations seem appropriate.

1. Large and small group instruction focused on development of language skills most applicable to the school experience should become an integral part of the curriculum in low socio-economic elementary schools. This is especially true when the majority culture uses non-verbal communication in most social interactions. Under these circumstances, children have had little opportunity to develop language before entering school. Without these skills, verbal instruction and language intense curriculum become breeding grounds for failure.

2. Social and coping skills should be taught to all incoming students on a comprehensive and consistent basis. Children must receive instruction in the behaviors expected from them in order for them to be "good students." When children come from dysfunctional homes with little or no structure, the demands of school are often beyond their coping skills. Even functional families rarely prepare their children fully for transition to school. Therefore, teachers will have to teach those skills if they expect the children in their classroom to experience school as a

positive, success-producing environment in which the child can maintain personal control.

3. Early screening should continue on a regular basis. Adequate appraisals in conjunction with classroom observations can provide a framework for instruction based on realistic, achievable goals for each child. Support services to remediate weaknesses and enhance strengths should enable the student to become a more competent, motivated, self-directed, responsible student.

4. Skill development and group support for teachers including on-going in-service should continue on a regular basis. All too often, teachers close the door to their rooms at eight in the morning and they remain isolated from meaningful collegiality until the end of the day. As the classroom becomes more challenging and problems more diverse, teachers will need validation and meaningful support from professional staff and administrators in order to prevent burn-out. This concept leads to the fifth recommendation -- on-going strategic planning.

5. Strategic planning in education tends to be a limited exercise undertaken to meet a specific goal within a given time frame. It became obvious during implementation of this practicum that teachers want to plan in order to be responsive to the ever changing demands of their classroom. Teaming, strategic planning, teacher empowerment, and risk-taking may be the factors that separate successful schools from inadequate, out-dated institutions. Administrators

must be trained in strategies to facilitate growth in their teachers. They must also receive support from their superiors when they try to incorporate those strategies at their own site.

6. Finally, teachers need to have realistic feedback about their classroom management techniques. Many know the appropriate strategy and, often, firmly believe that they use those strategies regularly. However, observation indicates that what teacher believe that they do and what actually transpires in classroom interactions are sometimes diametrically opposed.

Dissemination

Several aspects of this practicum have already been disseminated. The chart comparing causative factors often found in the background of academically delayed or behaviorally dysfunctional children has been made available for general distribution by resource teachers responsible for development of programs and curriculum that impact early childhood and primary level education.

Copies of the newly developed instrument designed to identify behavioral patterns and provide workable strategies to handle those problems in the classroom have been made available to exceptional education teachers and behavior management specialists throughout the county. Research supporting the choice of strategies and instruction in utilization of the instrument is available upon request.

Thirdly, a copy of the practicum has been given to the Director for Student Services, the Director for Psychological Services, and the Director for Exceptional Education Services for distribution to appropriate personnel.

A copy of the completed document is on file in the professional library.

Finally, the information gathered as a result of this practicum experience will serve as the basis for several articles to be submitted for journal publication.

References

Bandura, A. (1979). Psychological mechanisms of aggression, In von Cranach, M., Foppa, K., Lepenies, W., and Ploog, D. (Eds.) Human Ethology. Cambridge: Cambridge University Press.

Bandura, A. (1977). Social learning theory. Englewood Cliffs, NJ: Prentice-Hall, Inc.

Barkley, R., DuPaul, G., & McMurray, M. (1990). Comprehensive evaluation of attention deficit disorder with and without hyperactivity as defined by research criteria. Journal of Consulting and Clinical Psychology, 57(6), 775-789.

Bartel, N., & Thurman, K. (1992). Medical treatment and educational problems in children. Phi Delta Kappan, 74(1), 57-66.

Barth, R.P. (1991). Educational implications of prenatally drug-exposed children. Social Work in Education, 13 (2).

Bauer, A. (1991). Drug and alcohol exposed children: Implications for special education for students identified as behaviorally disordered. Behavioral Disorders, 17(1), 72-79.

Bauer, A., Buschbacher, P.W., Ellis, G.E., & Whelley, J. (1990). Parenting children who have been prenatally exposed to drugs or alcohol: A handbook for foster and adoptive parents. Cincinnati, OH: Cincinnati University. (ERIC Document Reproduction Service No. ED 336 2104)

Breiner, S.J. (1987). Qualities and Characteristics of the Child Abusing Population. Paper presented at the Annual Children's Center Spring Conference. Detroit, MI. (ERIC Document Reproduction Service No. ED 282 145)

Burgess, D.M., & Streissguth, A.P. (1992). Fetal alcohol syndrome and fetal alcohol effects: Principles for educators. Phi Delta Kappan, 74(1), 24-34.

Center for Early Education and Development. (1990, April). Children of cocaine: Facing the issues. Minneapolis, MN. (ERIC Document Reproduction Service No. ED 320 358)

Cole, C.K., Jones, M., & Sadofsky, G. (1990). Working with children at risk due to prenatal substance exposure. Prise Reporter (Newsletter by the Pennsylvania Resources and Information Center for Special Education), 21(5).

Committee on the Judiciary, United States Senate, One Hundred Second Congress, First Session. (1992). Cocaine kindergartners: Preparing for the first wave. Hearing on the impact drug abuse is having on children. (ISBN-0-16-037178-3; Senate-Hrg-102-367). Washington, D.C: U.S. Government Printing Office.

Craig, S. (1992). The educational needs of children living with violence. Phi Delta Kappan, 74(1), 67-71.

D'Entremont, D. (1990). Intervention strategies for school age children with fetal alcohol syndrome. Gorham, ME: University of Southern Maine. (ERIC Document Reproduction Service No. ED 334 514)

Durbin, K. (1993, February). Attention Deficit Hyperactivity Disorder. Streamlined Seminar, 11(4).

Durfee, M., & Tilton-Durfee, D. (1990, August). Interagency intervention with perinatal substance abuse. Children Today, 19(4), 30-32.

Erickson, M., Farber, E., & Egeland, B. (1982). Antecedents and concomitants of compliance in high-risk preschool children. Paper presented at the annual meeting of the American Psychological Association, Washington, D.C.

Fejes-Mendoza, K. (1991). Drug-exposed infants: Outlook on education (Contract No. 300-87-0700). Washington, D.C: Department of Education. (ERIC Document Reproduction Service No. ED 340 168)

Folz, C. (1990). Effects of fetal cocaine exposure and implications for teachers of exposed children. Wayne, NJ: William Patterson College School of Education. (ERIC Document Reproduction Service No. ED 337 920)

Gittler, J., & McPherson, M. (1990). Prenatal substance abuse. Children Today, 19(9), 3-7.

Gregorchik, L.A. (1992). The cocaine-exosed children are here. Phi Delta Kappan, 73(9), 709-711.

Griesbach, L., & Polloway, E. (1990). Fetal alcohol syndrome: Research review and implications. Lynchburg, VA: Lynchburg College, School of Education and Human Development. (ERIC Document Reproduction Service No. ED 326 035)

Griffith, D. (1992). Prenatal exposure to cocaine and other drugs: Developmental and educational prognoses. Phi Delta Kappan, 74(1), 30-34.

Harpring, J. (Ed.). (1991). Cocaine babies: Florida's substance exposed youth. Prevention Center. Tallahassee: Office of Policy Research and Improvement (OPRI), Florida Department of Education.

Horowitz, R. (1990). Perinatal substance abuse: A coordinated public health and child welfare response. Children Today, 19(4), 8-12.

Howard, J., Beckwith, L., Rodning, C., & Kropenske, V. (1991). The development of young children os substance-abusing parents: Insights from seven years of intervention and research. In J. Harpring (Ed.), Cocaine babies: Florida's substance exposed youth. Prevention Center (p. 93). Tallahassee: Office of Policy Research and Improvement (OPRI), Florida Department of Education.

Howes, C. (1989, September). Infant child care. Young Children, 44(6), 24-28.

Howze, K., & Howze, W. (1989, November). Children of cocaine: Treatment and child care. Paper presented at the Annual Conference of the National Association for the Education of Young Children, Atlanta, Ga.

Linehan, M. (1992). Children who are homeless: Educational strategies for school personnel. Phi Delta Kappan, 74(1), 61-66.

Lockwood, S.E. (1990). What's known--and what's not known-about drug-exposed infants [Special issue]. Youth Law News. 15-18.

Lumsden, L. (1990). Meeting the special needs of drug-affected children. Washington, D.C: Office of Educational Research and Development. (ERIC Document Reproduction Service No. ED 321 424)

Minisman-Chin, L., Snyder-Spatarella, K., & Tansey, S. (1991). Crack/cocaine: An overview and directory. City University of New York, New York, New York. (ERIC Document Reproduction Service No. ED 334 805)

Needleman, H. (1992). Childhood exposure to lead: A common cause of school failure. Phi Delta Kappan, 74(1), 35-39.

Otto, M., & Brown, R. (1985). Group treatment for abusive parents. Paper presented at the Annual Convention of the American Association for Counseling and Development, New York, NY.

Pinkerton, D. (1991). Substance exposed infants and children. Reston, VA: Council for Exceptional Children; ERIC Clearinghouse on Handicapped and Gifted Children. (ERIC Document Reproduction Service No. ED 340 149)

Prenatally Exposed to Drugs (PED) Program. (1989, July). Today's Challenge: Teaching Strategies for Working with Young Children Prenatally Exposed to Drugs/Alcohol. Los Angeles, CA: Los Angeles Unified School District: Division of Special Education.

Rancer, A., & Niemasz, J. (1988). The influence of argumentativeness and verbal aggressiveness in intrafamily violence. Paper presented at the Annual Meeting of the Eastern Communication Association, Baltimore, MD.

Rickarby, G. (1984). The detached or inured child (Unit for Child Studies Selected Papers Number 31). Kensington, Australia: New South Wales University, School of Education.

Rist, M. (1990, January). The shadow children. The American School Board Journal. 19-24.

Select Committee on Narcotics Abuse and Control, House of Representatives, One Hundred Second Congress, First Session. (1991). Drug-exposed kids: A crisis in American schools. (ISBN-0-16-037040-X; SCNAC-102-1-11). Washington, D.C: U.S. Government Printing Office.

Stevens, L., & Price, M. (1992). Meeting the challenge of educating children at risk. Phi Delta Kappan, 74(1), 18-23.

Straus, M., & Kantor, G. (1988). Stress and child abuse. In Ray E. Helfer & Ruth S. Kempe (Eds.), The battered child (p 49). Chicago: University of Chicago Press.

Streissguth, A.P., Sampson, P.D., & Barr, H.M. (1989). Neurobehavioral dose-response effects of prenatal alcohol exposure in humans from infancy to adulthood. In D. Hutchings (Ed.), Prenatal abuse of licit and illicit drugs. Annals of the New York Academy of Sciences, 562, 145-158.

Swanson, J. (1993). Developing prosocial problem-solving skills in elementary school children through the introduction of an anger-management curriculum. Manuscript submitted for publication.

Swanson, J. (1992). A discussion and review of the literature on sexual abuse and family violence. Unpublished manuscript, Nova University, Center for the Advancement of Education.

Vincent, L. J., Poulsen, M. K., Cole, C.K., Woodruff, G., & Griffith, D.R. (1991). Born substance exposed, educationally vulnerable. Reston, VA: ERIC Clearinghouse on Handicapped and Gifted Children.

Wright, J. (1982). Chemical dependency and violence: Working with dually affected families. Madison, WI: Wisconsin Clearinghouse.

APPENDIX A

STUDENT BEHAVIOR INVENTORY

(An Assessment and Strategies Instrument)

STUDENT BEHAVIOR INVENTORY

with

RELATED TEACHING STRATEGIES

designed by

Constance J. Turner
May 1993

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STUDENT BEHAVIOR INVENTORY

Instructions for Use of the Inventory

1. Read the observable behaviors and descriptions by each numbered item.

2. If a behavior or description applies to a student, place a check mark in the space next to that item's number.

3. When the inventory has been completed, use the overlay located behind each sheet of descriptors to determine the categories of the behaviors checked.

4. If a group of checks occur within a category, a problem is indicated.

5 Turn to the TEACHING STRATEGIES section to choose strategies appropriate for use with a child with the identified behavior problems.

Student Behavior Inventory

1.___ a. tests or questions teacher authority
___ b. makes every issue a public one
___ c. causes turmoil in class over minor issues
___ d. keeps "pushing" until he gets into trouble
___ e. involves others in verbal combat
___ f. teacher becomes confused, angry

2.___ a. disrupts class with wise cracks
___ b. won't quit until he gets attention
___ c. prevents other students from concentrating
___ d. regaining class momentum for teacher is difficult, because students may linger on humor
___ e. teacher is concerned others will imitate
___ f. attention seeker
___ g. knows no boundary for attention getting
___ h. likes to perform in front of opposite sex
___ i. distracts class from subject
___ j. teacher feels loss of control of class
___ k. other students may provoke him to deviate class

3.___ a. challenges teacher
___ b. talks back
___ c. dares punishment
___ d. makes teacher feel uneasy

4.___ a. disturbs students and teacher
___ b. acts silly, foolish, drops things, makes noises
___ c. annoys teacher and classmates
___ d. demands attention, time consuming

5.___ a. is disorganized
___ b. fails to bring supplies
___ c. draws, daydreams, out of seat
___ d. short attention span
___ e. teacher feels failure because student won't respond or complete assignments
___ f. other students try to get by without completing assignments

6.___ a. can't sit still
___ b. plays with objects
___ c. out of seat frequently
___ d. pesters students
___ e. teacher and class mates feel tense, anxious
___ f. teacher feels that he is constantly dealing with the behavior

7.___ a. doesn't do assignments
___ b. doesn't listen
___ c. says "I don't care" all of the time
___ d. class is interrupted
___ e. teacher feels frustrated
___ f. "don't care" attitude becomes contagious

8.___ a. won't try new tasks
___ b. may start, but stops
___ c. argues
___ d. makes excuses for what he didn't get done
___ e. teacher feels frustrated
___ f. teacher spends a lot of time dealing with it
___ g. student and teacher have confrontations in a win/lose situation

9.___ a. makes comments, opinions, ask questions that take class attention away from subject
___ b. mumbles or makes noises
___ c. laughs or talks at inappropriate times
___ d. learning situation is disrupted
___ e. teacher becomes involved in power struggles
___ f. teacher may regard interruption as insult

10.__ a. loves to talk
__ b. short attention span
__ c. often doesn't realize he is talking
__ d. classmates and teacher are annoyed
__ e. lessons are disrupted
__ f. teacher has to reprimand continually]

11.__ a. stirs up trouble, fights
__ b. doesn't care about consequences
__ c. poor self concept
__ d. teacher is irritated
__ e. class is disrupted
__ f. some classmates are afraid of this student

12.__ a. does not use adult for comfort or play approval
__ b. shows no preference for a particular adult
__ c. does not respond to praise from an adult
__ d. ignores verbal/gesture limit setting
__ e. does not express fear, grief, worry
__ f. clings to teacher

13.__ a. delayed receptive and expressive language
__ b. unable to follow directions
__ c. unable to verbalize needs, wants: expresses through banging, stomping, shouting
__ d. listless, passive
__ e. observes, rather than verbally engages with peers
__ f. initiates interaction with peers by hitting, pushing, biting, negative verbal remarks

Teacher Strategies for Behavior Problems

MANIPULATOR:

1. Use the "caution-warning" method. Say "I know you are upset because of what you said....but let's not say anymore." This allows the student a second chance to respond in an appropriate manner. It also prevents a discipline problem from developing while letting the student know that you are aware of the situation.

2. Handle the situation in a professional manner rather than reacting to it personally.

3. Recognize the student's need to be heard. Do not provide him with an audience. If he doesn't get the attention that he wants from you, he will seek it from another source.

4. Don't feel compelled to give immediate answers. Give an answer as soon as possible.

5. Tell the student "no" or "yes" and why in a respectful manner. Explain why your decision is best for the learning situation in the classroom.

ATTENTION SEEKER (Class Clown):

1. Don't ignore this student!

2. Enjoy the humor briefly with the class. The humor is not the major problem. Not knowing when to quit is always the problem. Use signals rather than words to indicate that "enough is enough."

3. Fulfill the need for attention at a time when the student is not "cutting up."

4. In private conferences use a "time and place" strategy.

5. Do not try to outwit the student.

6. Be aware that this child often needs more than attention. He often feels he must do something to win approval.

7. The best way to make a person feel important is to give them something to do. Make a list of things that need to be done weekly, or daily, and ask this student if he would be willing to do them. Remember to **RECOGNIZE HIS EFFORTS.**

DEFIANT:

1. Regardless of the situation, never get into a "yes you will" contest. Silence is a better response.

2. DO NOT raise your voice to argue with this student.

3. Use the third person technique. You are not the cause of the student's defiance...unless you are shouting or handling him with sarcasm. Say "What's the matter? That doesn't sound like you?" This helps you maintain your dignity, but also conveys the message to the class that the defier is the problem, not you.

4. If the student says "I won't do it" or "You can't make me," stay in the third person by saying "What's the matter?" "Do you need help?" Don't lose your composure.

4. The "delayed teacher reaction" works, too. If a student says "I won't do it," do not say anything at first. Then say, "Let's not talk about it here. Let's visit later when you can tell me what's on your mind."

DISRUPTER:

1. The disruptive student has two needs: attention and success. DO NOT respond with rejection.

2. Provide positive experiences that will meet the child's needs for achievement and happiness. You will stop the behavior.

3. Be aware of the causes of the disruptive behavior such as feeling of inadequacy, anger, and conceit which lead to behaviors such as bullying, over reaction, and showing off.

4. It is better to "use calm" to "regain calm" in the case of an abrupt disturbance. Simply pause, then say, "I'm glad that is over with." Then regain momentum.

5. Misbehavior can be the direct result of academic frustration. A student may demonstrate this frustration by crumpling and throwing his paper or slamming his book. Assist this student rather than reprimand.

OFF TASK (Distracted or Does Nothing):

1. Create a verbal or written agreement with this child to encourage self motivation.

2. Use positive reinforcement as much as possible.

3. Talk to the student frequently. Check progress of work continuously.

4. Deal honestly with what the child is feeling.

5. Seek help from the support staff; set up a parent conference.

ACTIVE CHILD:

1. There may be a medical reason for the child's behavior. Medication prescribed by a doctor may be necessary. However, the behavior may be due to stress, family life, or other emotional components.

2. Do not force the child to sit for long periods of time. He simply cannot do it. Arrange for him to move at intervals planned by you as a reward system.

3. Design short term goals. Find activities that will absorb the need to be active such as passing out papers or cleaning tables.

4. Give positive reinforcement to the child when he is quiet.

5. Make improvement your goal. Chart how many times the student has to be corrected. Let the student keep a chart so he learns self-monitoring. Use signals which allow you to correct the student without disturbing the class.

WITHDRAWN:

1. Be aware that the child probably does care. Say "You do care, that's why you are reacting this way. I'm going to help you whether you care or not."

2. Ask "What are you worried about?" This is the real problem.

3. Teach in a way that the child can have success. Use all modalities (auditory, visual, motor, kinesthetic, tactile, vocal).

4. Point out the good things that the student has done.

5. Shorten assignments.

COMMUNICATION STRATEGIES FOR AT-RISK CHILDREN:

1. Create a stable environment where the child feels safe to express his feelings, wants, and needs.

2. Give simple, one step directions. Gradually increase the steps.

3. Provide names of people, food items, body parts, objects, feelings, and events in the process of communication.

4. Acknowledge the child's needs, wants, or fears.

5. Reflect the child's feelings.

6. Immediately respond to beginning attempts at verbal communication.

7. Use hands-on activities to reinforce the child's language.

NON-COMPLIANT:

1. Make your expectation for this student VERY CLEAR. State the choices that are available. Show him the consequences. "That's fine, but this is what I must do if you don't try."

2. Follow through with the stated consequences.

3. Set reasonable goals for the student.

4. Remain calm. Don't react personally.

5. When correcting this student, preface a negative comment with a positive one.

TROUBLE MAKER:

Experience reveals that those students who are inclined to give teachers trouble seem to seek out certain teachers. Students label them as weak. The problem will not get better until the teacher changes his way of operating.

1. Consistent trouble-making is a sign of distress. Communication is a must. The person needs to get the distress "off his chest."

2. Acknowledge irrational behavior. Help the student realize that the behavior is temporarily out of character and that you will make temporary allowances.

3. Reassure the trouble-maker that you really do care.

INTERRUPTER:

1. Whenever possible, continue teaching. Confront the student only if the behavior stops the flow of the lesson.

2. After the second or third incident, stop the student and say, "Let's stay with the topic at hand. And I will see you...." Have a private conference with the student at the first opportunity.

3. In the conference tell the student that he is interrupting the class. Make sure that he knows you are serious.

4. If there is the possibility that the student is "game playing," say "If by chance you are doing this on purpose, then I think we have a bigger problem than you can handle." Usually the student will apologize and try to convince you that it was not done on purpose.

5. Look for improvement and give positive feedback to the student.

SOCIAL/EMOTIONAL STRATEGIES FOR AT-RISK CHILDREN:

1. Provide opportunities for warm, positive contact throughout the day.

2. Address the child by name. Elicit eye contact. Touch the child before giving a verbal command.

3. Use books, pictures, dolls, and conversation to explore and help the child express a range of feelings.

4. Take every opportunity to develop teacher-child relations.

5. Communicate with care giver. Be aware of upset or changes in the home.

6. Assist the child in gaining control by: getting eye contact, sitting next to the child; verbal reassurances; physical comfort.

TALKATIVE:

1. This is a social problem not a discipline problem.

2. React consistently. Never punish irrationally. Don't get on the talker one day and ignore him the next.

3. Tell the student that you will call on him during class discussion. Reinforce positive contributions.

4. Keep the student near a quiet student or near you.

APPENDIX B

WRITER DESIGNED PRE/POST TEST

PRE/POST TEST

1. Please give your definition of the following words:
   a. dysfunctional student _____

_____.

   b. mainstreaming _____

_____.

   c. exceptional education student _____

_____.

2. List five dysfunctional behaviors you might expect to see in your classroom this year.
   a.

   b.

   c.

   d.

   e.

3. Give three different possible causes of the above behaviors.

   a.

   b.

   c.

4. Name one way that a dysfunctional student differs from an exceptional education student._____

_____.

5. Name three indicators that might make a dysfunctional child appropriate for referral for exceptional education services.

   a.

   b.

   c.

6. List three teacher responsibilities in completing a referral for exceptional education.

a.

b.

c.

7. Name four members of the multidisciplinary team and identify their services.

a.

b.

c.

d.

8. Identify two teaching strategies to meet the ACADEMIC needs of the dysfunctional student.

a.

b.

9. Identify three strategies to address behavioral/affective needs of the dysfunctional child in the mainstream classroom.

a.

b.

c.

10. What does I.E.P. stand for? _____

11. Name one strategy that you might suggest for inclusion on the IEP that could be incorporated into the mainstream classroom.

_____

_____.

APPENDIX C

TEACHER SELF-REPORT PREFERRED STRATEGIES INVENTORY

TEACHER SELF-REPORT ON STRATEGIES CURRENTLY USED WITH THE ACADEMICALLY AND BEHAVIORALLY AT-RISK STUDENT

1. Name: _____

2. Number of Students: _____

3. Do you currently have students in your classroom that you would consider to be academically or behaviorally at-risk?

   Yes _____

   No _____ _____

   If yes, how many are behaviorally at-risk? _____

   academically at-risk? _____

4. I am most comfortable teaching (mark **all** that apply):

   _____ at-risk

   _____ academically delayed

   _____ behaviorally acting out

   _____ all of the above

   _____ none of the above.

5. I have noticed an increase in the number of children this year who are not prepared for my grade level/activity.

   _____ yes

   _____ no

6. If you answered yes to the above question, what percentage of your class do you estimate to be unprepared?

   _____%

I appreciate your time---hang in there, just a little more to go!!

7. Which of the following behaviors do they exhibit?

_____ poor listening skills

_____ poor letter recognition

_____ poor reading skills

_____ tests authority

_____ argues with adults/peers

_____ is disorganized

_____ can't follow instructions

_____ hyperactive

_____ makes random noises

_____ has an "I don't care" attitude

_____ belligerent

_____ fights physically
_____ verbally

_____ refuses to do new tasks

_____ short attention span

_____ doesn't do homework/classwork

_____ verbalizes sense of frustration, failure

_____ is significantly **below** grade level

8. I feel that the workshop is valuable and necessary.

_____ yes

_____ no

Which strategies do you use most often?

MARK ONLY THOSE STRATEGIES THAT YOU ACTUALLY USE!

Occasionally	Frequently	
_____	_____	1. Recognize student's needs.
_____	_____	2. Explain answers/decisions.
_____	_____	3. Give attention for positive behavior.
_____	_____	4. Set firm rules.
_____	_____	5. Give warnings/follow through.
_____	_____	6. Shorten assignments.
_____	_____	7. Provide one-on-one instruction.
_____	_____	8. Ignore inappropriate behavior.
_____	_____	9. Recognize student's emotions.
_____	_____	10. Isolate uncooperative students.
_____	_____	11. Provide punishment for infraction of the rules.
_____	_____	12. Refer for discipline.
_____	_____	14. Remain calm and avoid confrontation.
_____	_____	15. Help child organize self.
_____	_____	16. Use third person - especially when the student is confrontive.
_____	_____	17. Reflect child's feelings.
_____	_____	18. Provide warm, positive contact throughout day.
_____	_____	19. Communicate your needs for student behavior in a calm, consistent manner.
_____	_____	20. Monitor level of stimulation for the overactive child.
_____	_____	21. Provide hands-on activities throughout the day.

APPENDIX D

WRITER DESIGNED OBJECTIVE OBSERVATION INSTRUMENT

TEACHER_____

GRADE LEVEL_____

DATE:_____ Observation # ___1 ___2 ___3

Domain	Teacher Behaviors	Total Freq	Frequency	Frequency	Total Freq	Teacher Behavior	Domaine
1.0	Delays reaction					Reacts immediately	1.0
	Remains calm/non-confrontive					Becomes confrontive	
	Stays in the third person					Personalizes argument	
	Confers with student privately					Confronts student in public	
	Explains					Neglects to explain	
	Make expectations clear					Expectations unclear	
	Assigns reasonable consequences to non-compliance					Picks unreasonable or unrelated consequences	
	Is consistent					Lacks consistency	
	Follows through					Lacks follow through	
	Prefaces negative comment with a positive comment					Is negative	
2.0	Validates student's need to be recognized					Does not validate student feelings	2.0
	Acknowledges irrational behavior					Ignores irrational behavior	
	Gives recognition at appropriate times					Fails to give timely recognition	
	Reinforces acceptable behavior immediately					Does not reinforce acceptable behavior	
	Offers positive opportunities for success					Misses opportunities for success	
	Anticipates potentially disruptive situations					Does not recognize potential disruptions	

Check behavioral category of child being observed.

Domain 1:	Domain 2:	Domain 3:	Domain 4
Manipulator	Attention Seeker	Off-Task	At Risk
Non-Compliant	Show-Off	Doesn't Care	
Defiant	Active	Withdrawn	
Trouble-Maker	Class Clown	Does Nothing	
Aggressive	Interrupter		
Disruptive	Talkative		

TEACHER_____

GRADE LEVEL_____

DATE:_____ Observation # ___1 ___2 ___3

Domain	Teacher Behavior	Total Freq	Frequency	Frequency	Total Freq	Teacher Behaviors	Domaine
3.0	Adjusts curriculum to permit student success					Fails to adjust curriculum	3.0
	Develops short term goals					No short term goals	
	Checks progress frequently					Ignores student	
	Uses positive reinforcement when the student is "on task"					Fails to reinforce when student is "on task"	
	Talks with student alone when needs to correct or criticise					Handles discipline in front of the class	
4.0	Provides opportunity for teacher-student contact					Remains aloof	4.0
	Smiles, conveys positive regard					Fails to smile	
	Acknowledges child's needs, fears, frustrations					Does not validate child's emotions	
	Reflects child's feelings					Fails to reflect feelings	
	Provides reasonable, articulated structure					Disorganized/ unstructured	
	Establishes stability					Confusion	
	Is consistent					Inconsistent	
	Assists child to establish self control					Does not help child establish self control	
	Is positive					Negative	
	Gives simple directions					Gives complex directions	

Check behavioral category of child being observed.

Domain 1:	Domain 2:	Domain 3:	Domain 4
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Defiant	Active	Withdrawn	
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